

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 1 9 4 2  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
WILLIAM		MANNING		ABELL				August 22, 1982								1015 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		Dec. 4 1898		83 years YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD	
Hollywood, Md.		U.S.A.				St. Mary's											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Leonardtown		St. Mary's Hospital															
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Md.		St. Marys		Hollywood				Rt. 3 Box 144									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST			
John		Lewis		Abell				Jane		Loretta		Wible					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		577-05-5255A		Myrtle Abell		same as 13e											

<b>10. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>hrs.</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Consistent Heart Failure, Nephrosclerosis*

CERTIFICATE	1% DATE OF OPERATION	1% CONDITION FOR WHICH OPERATION WAS PERFORMED	2% AUTOPSY?	2% IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

MEDICAL CERTIFICATE	21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 1970, to 8/22, 1982 that (I) was lost saw the deceased alive on 8/22, 1982, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. My best knowledge

72b. SIGNATURE <i>James P. Jarboe M.D.</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	72c. DATE SIGNED 8/24/82
72d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Jarboe, M.D.	72e. ADDRESS Leonardtown, Md		

23a. BURIAL, CREMATION, REMOVAL (SPRINT)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	8/24/82	Charles Memorial Gardens	Leonardtown	St. Mary's	

24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	25a. DATE REC'D. BY REGISTRAR AUG 25 1982	25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

ITEMS #5&6 Film G570 8/11 82 rc				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 1 9 4 3			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				P.			
HELEN FLORENCE ALVEY				August 3, 1982				12:38 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. YRS.		8. MONTHS	
Female		Caucasian		1905		72 years					
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.		NEVER MARRIED		St. Mary's				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
Leonardtawn		St. Mary's Hospital		(TYPE OF WORK FOR MOST OF WORKING LIFE)							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Charles		Waldorf		YES		865 Holly Tree Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
William S. Jenkins				Augusta Peed							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT			
No				217-36-9950				Barbara A. Lilley			
								same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery De.											
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES		NO	
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED			
OR CONTRIBUTING CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR				(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
(IF EITHER, NOTIFY MEDICAL EXAMINER)				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the doctor) attended the deceased from				19 65 to 8/3 19 82				that (I) (we) last saw the deceased alive on			
above (I) (we) did (do) not see the body after death.				and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
James P. Jarboe, M.D.								8/3/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
				Leonardtawn, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				8/5/1982		St. Francis Xavier		Compton St. Mary's Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley Leonardtown, Md.				AUG - 5 1982				John J. Clark			

BP



12:30

August 3, 1982

ALVAY  
May 5, 1982

PROBATION

HEALTH

St. Mary's

St. Mary's Hospital

Department

Handwritten notes and signatures, including a large signature that appears to be "James F. Garboe".

James F. Garboe, M.D.

James F. Garboe, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 21944

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST William Ignatius Alvey		2a. DATE OF DEATH MONTH DAY YEAR August 30, 1982		2b. HOUR M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.			
10 CITY OR TOWN OF DEATH Hollywood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Md. State Road		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Gen Del	
14 FATHER'S NAME FIRST MIDDLE LAST William H. Alvey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Buckler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 217-14-7822		17. INFORMANT ADDRESS 5601 Woodland Dr Anna Dell Ashley Forest Heights, Md.							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 Coronary artery occlusion with</u> DUE TO, OR AS A CONSEQUENCE OF <u>arrhythmia</u> (b) <u>atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a	
19a. DATE OF OPERATION 1978 - John's Hosp		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe Vascular occ. - femoral				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death									
22b. SIGNATURE Roy Guyther, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Roy Guyther, M.D.				22e. ADDRESS Mechanicsville, Md. 20659					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/2/82		23c. NAME OF CEMETERY OR CREMATORY Charles Mem. Grdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown St. Mary's Md.		23e. DATE RECEIVED BY REGISTRAR SEP 3 1982	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown, Md.				25a. DATE RECEIVED BY REGISTRAR SEP 3 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP \_\_\_\_\_



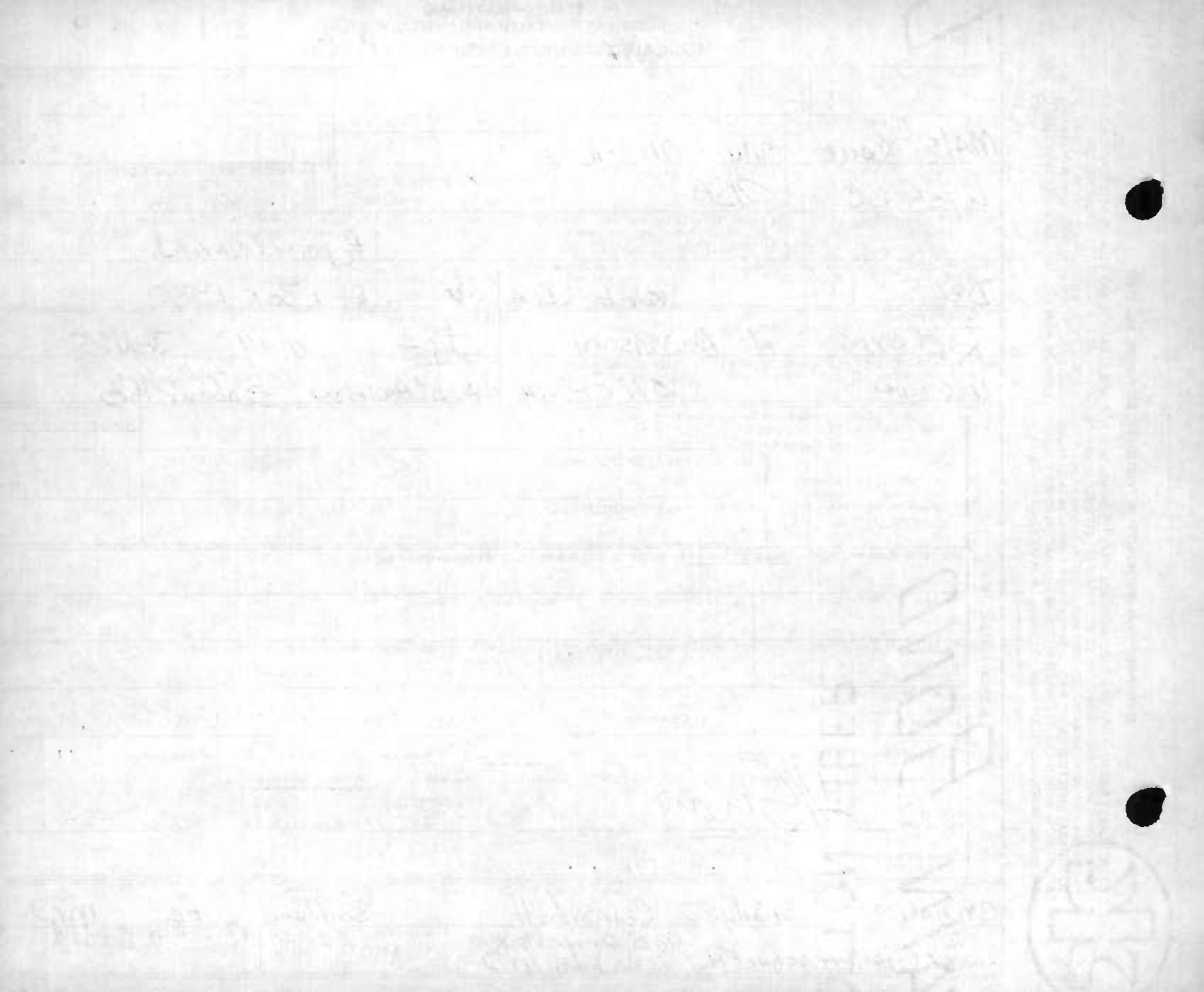


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21945 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Walter Anderson</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 26 1982</b>	
3. SEX <b>MALE</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 1 1911</b>		6. AGE (IN YEARS) (MONTHS) (DAYS) (HOURS) (MIN.) <b>70 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 29 1982</b>		7d. HOUR <b>6:00</b> P. M.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH DC</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County, MD.</b>				10. CITY OR TOWN OF DEATH <b>Chesapeake Bay</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chesapeake Bay</b>			
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>peopline man</b>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>DEL</b> COUNTY <b>13b. CITY OR TOWN</b> <b>Blacksburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>Rt 1 Box 1382</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard H Anderson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LDA MAY JONES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>UNKNOWN</b>				16b. SOCIAL SECURITY NO. <b>577-09-3296</b>				17. INFORMANT ADDRESS <b>DAVID ANDERSON 6503 99th Ave SEABOARD MS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9840 Drowning</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR <b>? P.M. 7 26 1982</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject found in water</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Chesapeake Bay near Point Look Out, St. Mary's Co., Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Heart causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>H. Guard</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>7-30-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>31 July 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Spartan PG MD</b>	
24. FUNERAL DIRECTOR NAME <b>Louis L Grant</b>				ADDRESS <b>2000 Landon FH. Landon MD</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 2 1 9 4 6

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mildred L. Biondi</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>82</b>			2b. HOUR <b>0150A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>17</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Marys</b> MD.	
10. CITY OR TOWN OF DEATH <b>Lexington Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Amber House</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>house wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Cleveland</b> MIDDLE <b>J.</b> LAST <b>Cooke</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Helen</b> MIDDLE <b>M.</b> LAST <b>Dohlman</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-20-8748</b>	
17. INFORMANT <b>Son-Paul E. Biondi</b>		18. ADDRESS <b>Same as Item #13</b>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1890

IMMEDIATE CAUSE (a)

**Carcinoma of Kidney with metastases**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 mths**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/22</b> , 19 <b>82</b> , to <b>8/11</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James Carroll Boyd, M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>August 11 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS			
<b>James Carroll Boyd, M.D.</b>		<b>P.O. Box 301</b>		<b>Leonardtwn, Maryland 20650</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug 13 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Washington</b> COUNTY <b>D.C.</b> STATE <b>D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Demaine Funeral Homes, Inc., Alex., Va. 22314</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 1 9 4 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT BEARD BOURKE</b>				2a. DATE OF DEATH <b>August 5, 1982</b>		2b. HOUR <b>10:25 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>Nov. 20, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House-keeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary</b>		13c. CITY OR TOWN <b>Maddox</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>James Porter Burke</b>				15. MOTHER'S MAIDEN NAME <b>unk.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-03-0315</b>		17. INFORMANT <b>Thelma C. Bourke, wife</b>		ADDRESS <b>513 Oglethorpe St., N.W. Wash., D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of Lungs</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>EMETASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1982</b> to <b>August 5, 1982</b> , that (I) (we) last saw the deceased alive on <b>August 5, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>V. K. Shah</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 5, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. K. Shah, M. D.</b>				22e. ADDRESS <b>Leonardtwn, Maryland 20650</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/10/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suburban Wash. D.C. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>McShine J.H.</b>				25. RECEIVED BY REGISTRAR (NAME) <b>Wash. D.C.</b>			

BP \_\_\_\_\_

10:25

August 25, 1962

BOULEVARD

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St. Mary's County

St. Mary's Hospital

Lebanon, Tenn.

CAFFELIN

20% COLLION



Lebanon, Tenn. 38050

V. K. Smith, N. D.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>THERESA IRENE BRAZIER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 26, 1982</b>		2b. HOUR <b>11:09PM</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH <b>37<sup>th</sup> 20<sup>th</sup> 1918<sup>th</sup></b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD			
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Piney Point</b>	13c. CITY OR TOWN <b>St. Marys</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmore Blackwell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Wilson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-12-4346A</b>		17. INFORMANT ADDRESS <b>Myra Barnett Piney Point, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma breast</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.						
22b. SIGNATURE <b>418200</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>Leonardtwn, Maryland 20650</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/30/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Cemetery Valley Lee St. Marys Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley Leonardtown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 1 1982</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP

11:00

March 22, 1962

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March 22, 1962

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St. Mary's County

St. Mary's Hospital

Leomontown

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Leomontown, Maryland 20650

March 22, 1962



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
RUFUS EUGENE CHEEK			August 24, 1982			9:35P					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Male			Black			Sept. 3, 1906			75 Years		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
N. Carolina			U.S.A.						St. Mary's		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtwn			St. Mary's Hospital								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			St. Marys			Lexington Pk.			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
William			Cheek			Pheobe			238-12-7126		
17. INFORMANT			ADDRESS			18. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Walter Cheek			same as 13e								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease with recurrent</u>			
4360			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <u>CVA + acute Aspiration Pneumonia</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24/82</u> 19 <u>82</u> , to <u>8/28</u> 19 <u>82</u> , that (I) (we) last saw the deceased at <u>St. Mary's Hospital</u> above, (I) (we) (and) (do) (not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
						8-25-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
James C. Boyd, M.D.		Leonardtwn, Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation		8/26/82		Cedar Hill		Suitland P.G. Maryland	

24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley Leonardtown, Md.		AUG 27 1982		John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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August 2, 1985

CHERRY

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WILLIAM

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St. Mary's Hospital

Leominster

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Leominster, MA

James O. Boyd, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21950	
1. DECEASED NAME (TYPE OR PRINT) <b>Leroy Charles Clinton</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 5 19 82</b>		2b. HOUR <b>0519</b>			
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 16, 1907</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 5 19 82</b>	7d. HOUR <b>0519</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Patuxent River</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Naval Hospital Pax. River</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Civil ser.</b>				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>St. Inigoes</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 65</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ellie Clinton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Kent</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>220-16-5205</b>		17. INFORMANT ADDRESS <b>Helen Clinton same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT LUNG</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>W.D. Boyd</b>		TITLE (SPECIFY) <b>DEPUTY</b>				MEDICAL EXAMINER		DATE SIGNED <b>8/6/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>WILLIAM D. BOYD, M.D.</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/9/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter Claver's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Inigoes St. Marys Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. Clarke Mattingley Leonardtown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lough</b>					

LOWE'S  
FARM  
NEW

100% COTTON

MADE IN THE U.S.A.  
100% COTTON  
MADE IN THE U.S.A.

1955

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MADE IN THE U.S.A.  
MADE IN THE U.S.A.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

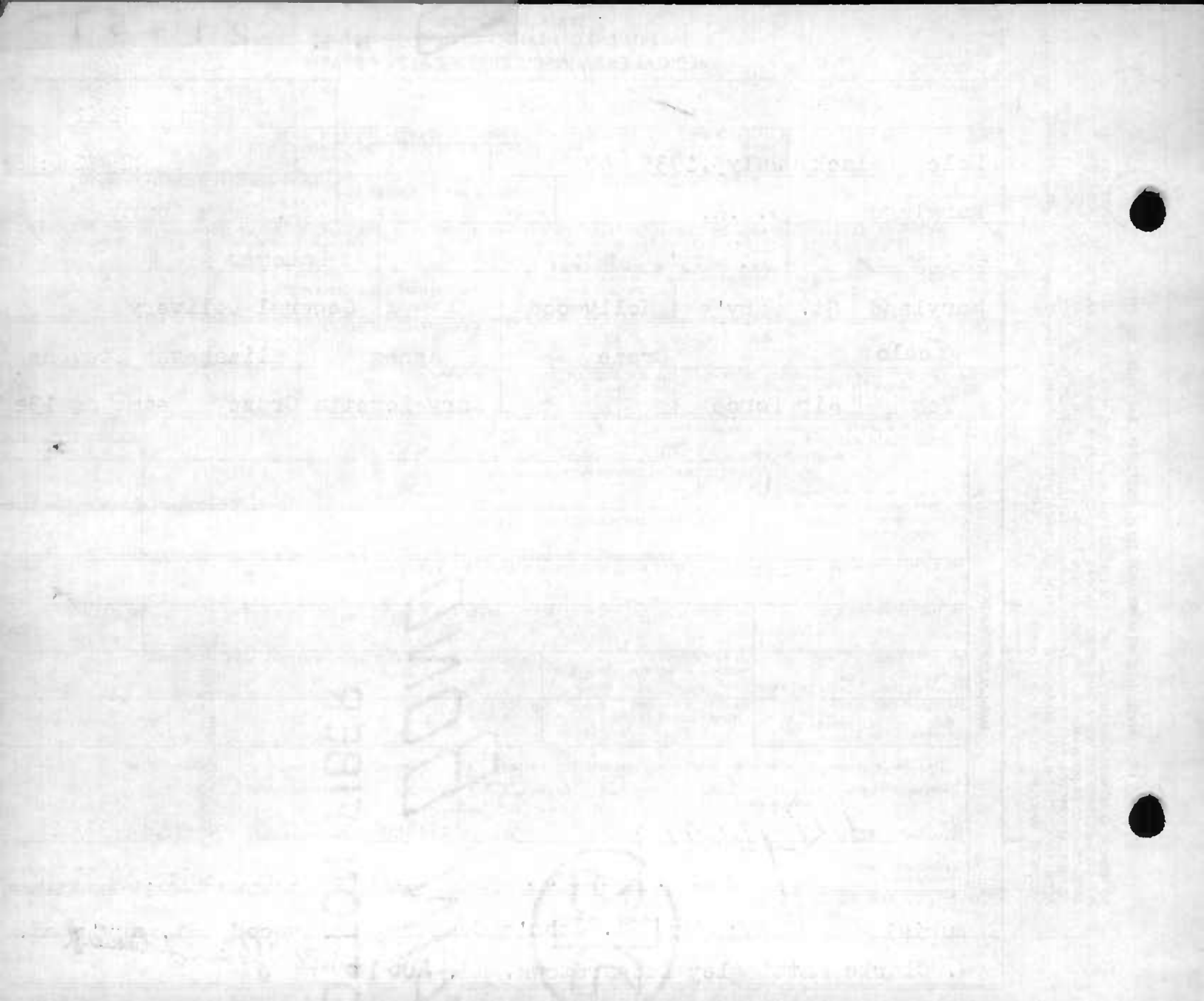
BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH										3. DATE OF ESTI MATED																																																											
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR																																																											
Andrew Levon Cruze										xx 8 12 82										M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.																													
Male										Black										July 5, 1935										47 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. NEVER MARRIED										10. WIDOWED										11. DIVORCED										12. BALTIMORE CITY OR COUNTY OF DEATH																			
Maryland										U.S.A.										X																																								St. Mary's County MD.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Leonardstown										St. Mary's Hospital										Laborer																																																											
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																							
Maryland										St. Mary's										Hollywood										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										General Delivery																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																													
Macelo										Cruze										Agnes Elizabeth Stevens										Yes										Air Force										Mary Loretta Cruze										same as 13e																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I DEATH WAS CAUSED BY:																																																																															
3030 IMMEDIATE CAUSE (a) Chronic alcoholism																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																																																															
(b)																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
										P.M. 19																																																																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																																											
22a. I certify that I took charge of the remains described above, held on death resulted from:										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																																					
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																															
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																											
H. R. Guard										M.D. Assistant										8/13/82																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
Hormez R. Guard, M.D.										111 Penn Street, Balto., MD 21201																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE																																																	
Burial										8/16/82										St. John's Cemetery										Hollywood St. Mary's Md.																																																	
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
W. Clarke Mattingley										Leonardtown, Md.										AUG 18 1982																																																											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0221952							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Harold Edward Davis				2a. DATE OF DEATH MONTH DAY YEAR Aug. 24 1982		2b. HOUR M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 2 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 years		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St/ Mary's County MD.			
10. CITY OR TOWN OF DEATH Chaptico		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Chaptico		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 95	
14. FATHER'S NAME FIRST MIDDLE LAST George Brent Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha America					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-36-6668		17. INFORMANT ADDRESS John K. Davis same as 13e					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer, lung</u> 4 months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>obstructive airway disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>57</u> to <u>Aug</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>April 24</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <u>David L. Mossman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David L. Mossman M.D.				22e. ADDRESS Rt 3 Bx 2 Mechanicsville, MD 20659					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/82		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION CITY OR TOWN COUNTY STATE Morganza St. Mary's Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtown, Md.		25a. DATE OF RECORD AUG 26 1982		25b. REGISTRAR'S SIGNATURE John J. Canfield	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified as such.

Item 11 per phone 8/25/82 dad				STATE OF MARYLAND			
1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF DEATH				REG. NO. 2 21953			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Glenn Elgin Goudie				MONTH DAY YEAR 8 9 82			
3. SEX				2b. HOUR			
Male				2310 M			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Caucasian		Sept. 19, 1906		75 years YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH			
Montana		U.S.A.		St. Mary's MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtwn		St. Mary's Hospital					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		St. Mary's		Leonardtwn		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST John Edmond Goudie		FIRST MIDDLE LAST Corabell Plumb		Rt. 2 Box 39			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Linaria Bernice Goudie same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARRYTHMIA</b>							IMMED.
4029 DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>							10 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-18</u> , 19 <u>71</u> , to <u>8-11</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5-3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>W.D. Boyd</u>				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8-11-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
WILLIAM D. BOYD, M.D.				LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		Aug. 11, 1982		Cedar Hill		Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley Leonardtown, Md.				AUG 13 1982		<u>John J. Conner</u>	

BP

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22. Mary's Hospital:

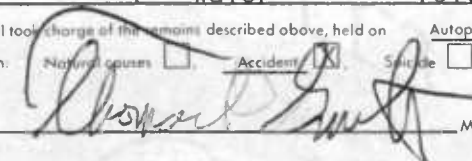
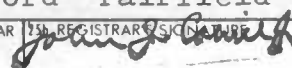
10-8

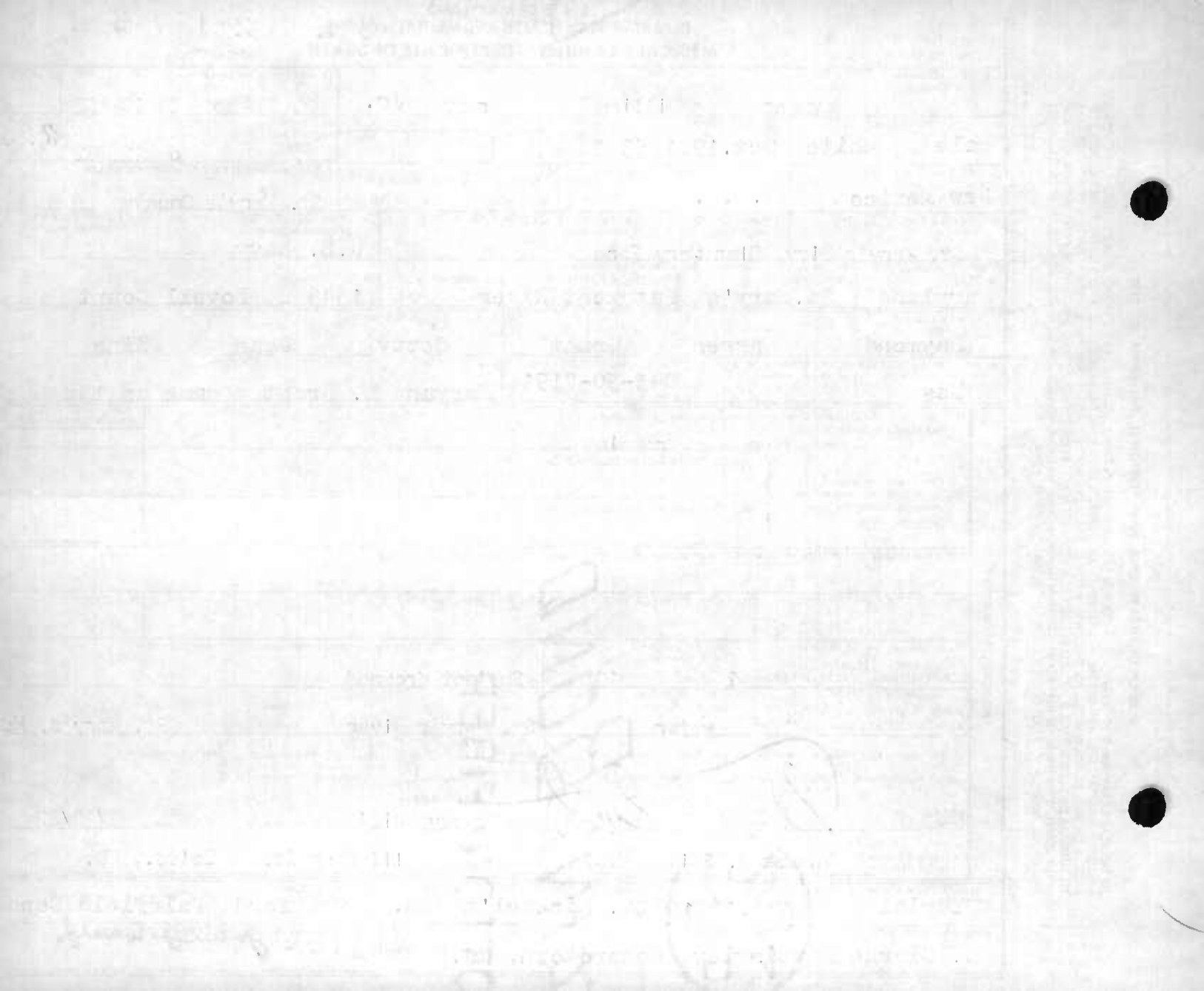
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21954 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond William Grant Jr.</b>										2a. DATE KNOWN OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>1982</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Oct.</b> DAY <b>19</b> YEAR <b>1953</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>28</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>12</b> YEAR <b>1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Mexico</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>St. Mary's City</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Glen Mary Farm</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>										13b. CITY OR TOWN <b>St. Mary's</b>	
13c. CITY OR TOWN <b>Patuxent River</b>										13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET ADDRESS <b>1543 B Lovell Court</b>											
14. FATHER'S NAME FIRST <b>Raymond</b> MIDDLE <b>Warren</b> LAST <b>Grant</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Betty</b> MIDDLE <b>Jean</b> LAST <b>King</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>045-50-7191</b>					17. INFORMANT ADDRESS <b>Maryann S. Grant same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9108</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>? P.M. 8 10 19 82</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Subject drowned</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>				21f. LOCATION STREET <b>St. Mary's River</b> CITY OR TOWN <b>St. Mary's, Md.</b> COUNTY <b>St. Mary's, Md.</b> STATE <b>MD.</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>M. Deputy Chief</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>				DATE SIGNED <b>8/12/82</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 16, 1982</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cem.</b>			
23d. LOCATION (CITY OR TOWN) <b>Stratford</b>				COUNTY <b>Fairfield</b>				STATE <b>Conn</b>			
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1982</b>	
25b. REGISTRAR'S SIGNATURE 											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				2 2 1 9 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN KENNEDY HILLERS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1982</b>		2b. HOUR <b>3:50P M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Tall Timbers</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John K. Hillers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lela Elizabeth Eliason</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT ADDRESS <b>Louise B. Hillers, Tall Timbers, Md. 20690</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>2050</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio pulmonary system (ischemic)</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 2 hr</b> <b>1 + 1/2.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>April 1981</b> to <b>Aug 4, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Aug 4, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John F. Fenwick, M.D.</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-5-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Fenwick, M.D.</b>				22e. ADDRESS <b>Leonardtwn, Md. 20650</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8-5-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Prince George's, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brinsfield Funeral Home, Leonardtown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carvish</b>	

MEDICAL CERTIFICATION

3:20P

August 11, 1902

JOHN F. TENNICK

St. Mary's County

St. Mary's Hospital

LEONARDTOWN

Leonardtown, Md. 20650

John F. Tennick, M.D.



CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 9 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8 2 2 1 9 5 6			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>Walter B. Huber, Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8/8/82</b>			
3. SEX <b>Male</b>				4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 29 1903</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Lexington Pk</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Marys</b> MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Amber House</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Member Congress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Legislative</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. CITY OR TOWN <b>Nanjemoy</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Henry Huber</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Marie Brennan</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> IF YES, GIVE WAR OR DATES				17. INFORMANT ADDRESS <b>Rt. 1, Box 251A</b>			
16b. SOCIAL SECURITY NO. <b>228-40-9231</b>				17. INFORMANT <b>Walter B. Huber, Jr. Nanjemoy, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Metastatic Lung Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-2-82</b> , 19____, to <b>8-8-82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>8-8-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Boyd</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 8, 1982</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Boyd, M.D.</b>				22a. ADDRESS <b>Leonardtown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-10-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Durham Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ironsides Chas. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>The Hunt Funeral Home, Waldorf, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

BP

• U. S. , byed mllll

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

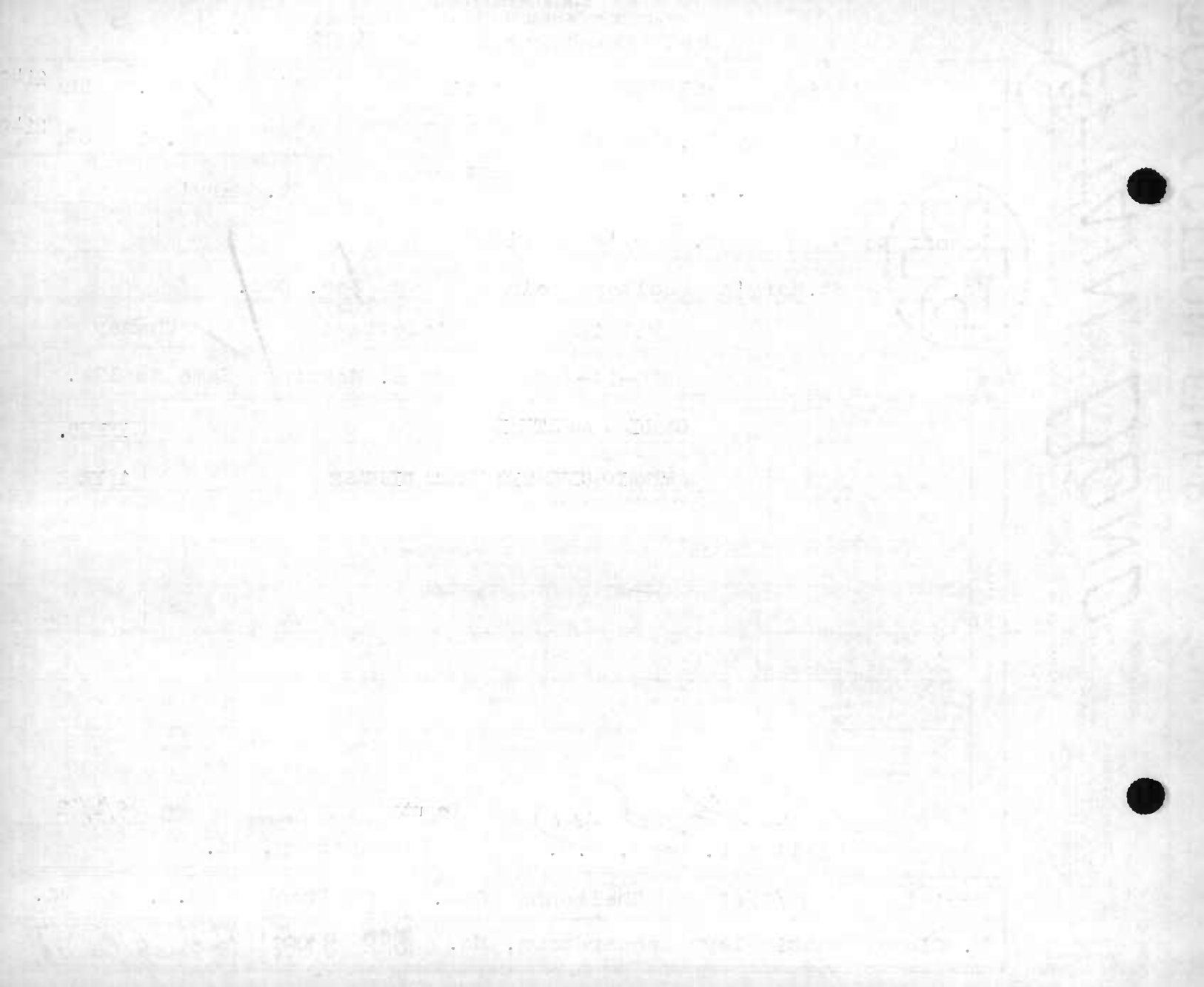
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21957

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b. HOUR
William Clifton Kesting					Aug. 31, 82				2149
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD
Male	White	July 19, 1925		57 YRS.	MONTHS DAYS HOURS MIN.				Aug. 31, 82
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		St. Mary's			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtwn		St. Mary's Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		St. Mary's		Coltons Point		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Gen. Del.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Elmer		William		Violetta Chaney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		220-14-4258		Norma E. Kesting Same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>CARDIAC ARRYTHMIA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4140 IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>									IMMED.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									1 YEAR
(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED			
[Signature]		M.D. Deputy				9/1/82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
William D. Boyd, M.D.		Leonardtwn, Md.							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		9/3/82		Cheltenham Cem.		Cheltenham P.G. Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley		SEP 3 1982		[Signature]					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				6 2 2 1 9 5 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY ALLENYA LUMPKINS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 13, 1982</b>		2b. HOUR <b>4:26A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 19, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County MD</b>	
10. CITY OR TOWN OF DEATH <b>Leonardtown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. CITY OR TOWN <b>St. Mary's Ridge,</b>		13c. STREET ADDRESS <b>Rt. 1, Box 36B</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Austin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Hammett</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-56-2429</b>		17. INFORMANT ADDRESS <b>Cecil Lumpkins Same as 13c.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2030</b> IMMEDIATE CAUSE (a) <b>Anaesthesia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Gastritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>Y125</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-5-82</b> , 19 <b>8-13-82</b> , to <b>8-13-82</b> , that (I) (we) last saw the deceased alive on <b>8-12-82</b> , 19 <b>8-12-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William D. Boyd, II M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd, II M.D.</b>				22e. ADDRESS <b>Leonardtown, Md. 20650</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/16/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ridge, St. Mary's Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley, Leonardtown, Md.</b>				25a. DATE RECD. BY REGISTRAR <b>AUG 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

BP

MARY ANN WILKINS August 13, 1902 1902

St. Mary's County

St. Mary's Hospital

Leominster

Leominster, MA. 01450

William J. 0074, II M.D.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21959  
REG. NO.

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. HOUR	
WILLIAM Ignatius MILES		8 17 1982		8 17 1982		12:20	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH	
Male	Black	Aug. 2, 1945	37 YRS.			St. Mary's County	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.				St. Mary's County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtwn	St. Mary's Hosp. (DOA)						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md.	St. Mary's	Piney Point	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Box 92			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS			
John Paul Miles		Elizabeth Roselie Holt		Theresa Ann Miles same as 13e			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		219-42-2628		Theresa Ann Miles same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY:							
8909 IMMEDIATE CAUSE (a) Smoke inhalation							
DUE TO, OR AS A CONSEQUENCE OF							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		11:12am 8-17-1982		House fire.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
		house		P.O. Box 92, Rt. 249, Pine Pt., St. Mary's Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
TITLE (SPECIFY)							
M.D. Assistant MEDICAL EXAMINER							
DATE SIGNED 8-18-82							
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)					
Ann M. Dixon		Ann M. Dixon, M.D.					
ADDRESS		111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		8/20/82		Charles Memorial Gardens		Leonardtwn St. Marys	
24. FUNERAL DIRECTOR		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley		AUG 20 1982		John J. Canfield			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2 2 1 9 6 0			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST LUCY BURROUGHS MILLARD				August 9, 1982 2:07 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own Home	
13a. STATE Maryland		13b. COUNTY Charles		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Rt. #2 Box 174	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence E. Burroughs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosetta Penn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-5762		17. INFORMANT ADDRESS O. Edward Millard Same as Line #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Congestive Heart Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Month.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) DUE TO, OR AS A CONSEQUENCE OF	
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/24/82 19 to 8/9/82 19, that (I) (we) last saw the deceased alive on 8/8/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (old) (did not) sign the body after death.							
22b. SIGNATURE William D. Boyd II, M.D.				DEGREE		22c. DATE SIGNED 8/9/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd II, M.D.				22e. ADDRESS Leonardtown, Md. 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-11-82		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Charles, Md.	
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Maryland				25a. DECEASED BY REGISTRAR SIGNATURE			

BP



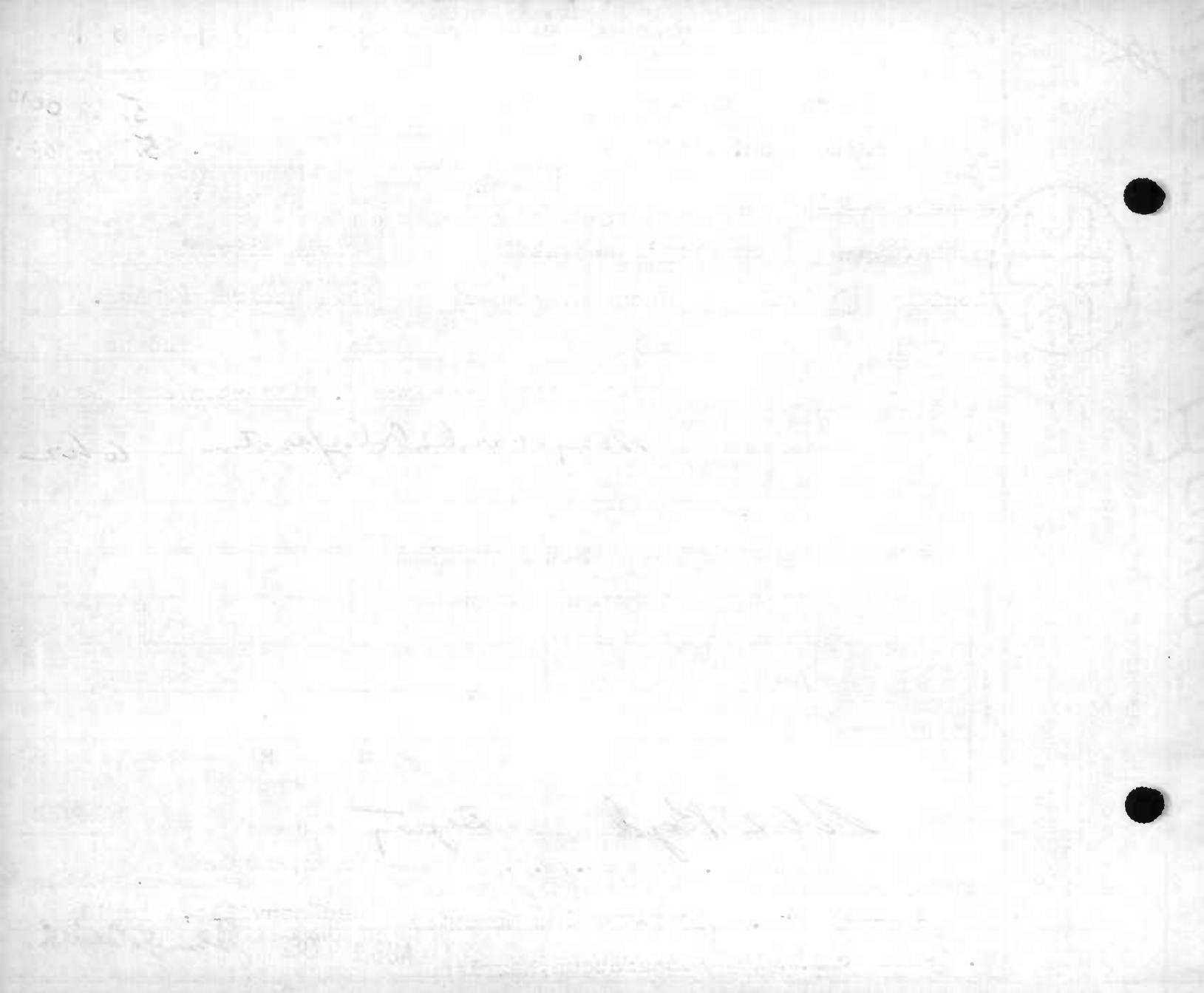


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21961 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) PEARL CAULEY PILKERTON										2a. DATE KNOWN OF DEATH MONTH DAY YEAR Aug 15 1982	
3. SEX FEmale		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1915		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 66		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Aug. 15, 1982		2b. HOUR 0010 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baxley, Georgia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.		
10. CITY OR TOWN OF DEATH Leonardtwn			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Florida			13b. COUNTY Duval		13c. CITY OR TOWN Jacksonville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1322 MacArthur Blvd.		
14. FATHER'S NAME FIRST MIDDLE LAST John Cauley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 255 14 9137A		17. INFORMANT ADDRESS Lawrence J. Pilkerton same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE W.D. Boyd				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 8/15/82			
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd Sr., M.D.				ADDRESS Leonardtwn, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 18, 1982		23c. NAME OF CEMETERY OR CREMATORY Riverside Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Jacksonville Florida		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland				25a. DATE REC'D BY REGISTRAR AUG 17 1982		25b. RECEIVED BY STATE ARCHIVES	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				2 2 1 9 6 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>SHADANA LATORE ROTHWELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 7, 1982</b>		2b. HOUR <b>3:55 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 7, 1982</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS <b>1 30</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md. St. Mary's</b>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>Rt. 1, Box 600</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donell Andrew Rothwell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sylvia Ann Carroll</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Sylvia Ann Rothwell Same as 13c.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>7611</b> IMMEDIATE CAUSE (a) <b>NEONATAL ASPHYXIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PREMATURITY - 17 WEEKS GESTATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PREMATURE RUPTURE OF MEMBRANES</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>8-7</b> , 19 <b>82</b> , to <b>8-7</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8-7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William C. Mulfred</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-27-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C. Mulfred, M.D.</b>				22e. ADDRESS <b>Leonardtwn, Md. 20650</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Charles Mem.Grdns</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leonardtwn, St. Mary's Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley, Leonardtown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1982</b>		25b. REGISTRAR'S SIGNATURE <b>J. Carroll</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Estelle RUCKER			2a. DATE OF DEATH MONTH DAY YEAR 8/2/82			2b. HOUR 3:30 PM					
3. SEX F		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 12 25 06		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FAIRFAX, VA.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.					
10. CITY OR TOWN OF DEATH LEXINGTON PK, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMBER HOUSE BOX 620 LEXINGTON PK, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE MARYLAND			13b. COUNTY P.G.		13c. CITY OR TOWN SUITLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3353 SOUTHERN AVE.		
14. FATHER'S NAME FIRST MIDDLE LAST William Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Jackson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-40-7615		17. INFORMANT ADDRESS MRS. RUBY FORD 3353 SOUTHERN AVE. SUITLAND MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1590 IMMEDIATE CAUSE (a) Terminal Ca of Bowel DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-20-82, 19 to 8-2-82, 19, that (I) (we) lost saw the deceased alive on 7-2-82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm D Boyd MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/2/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm D Boyd MD			22e. ADDRESS 17 Telford ST, FARM, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug-5-82			23c. NAME OF CEMETERY OR CREMATORY Prosperity Cem.			23d. LOCATION Chantilly, VA		
24. FUNERAL DIRECTOR NAME Bernard A. Am...			ADDRESS 8914 QUARRY RD MANASSAS, VA			25a. DATE REC'D. BY REGISTRAR AUG 11 1982					

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AY mda (50) 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

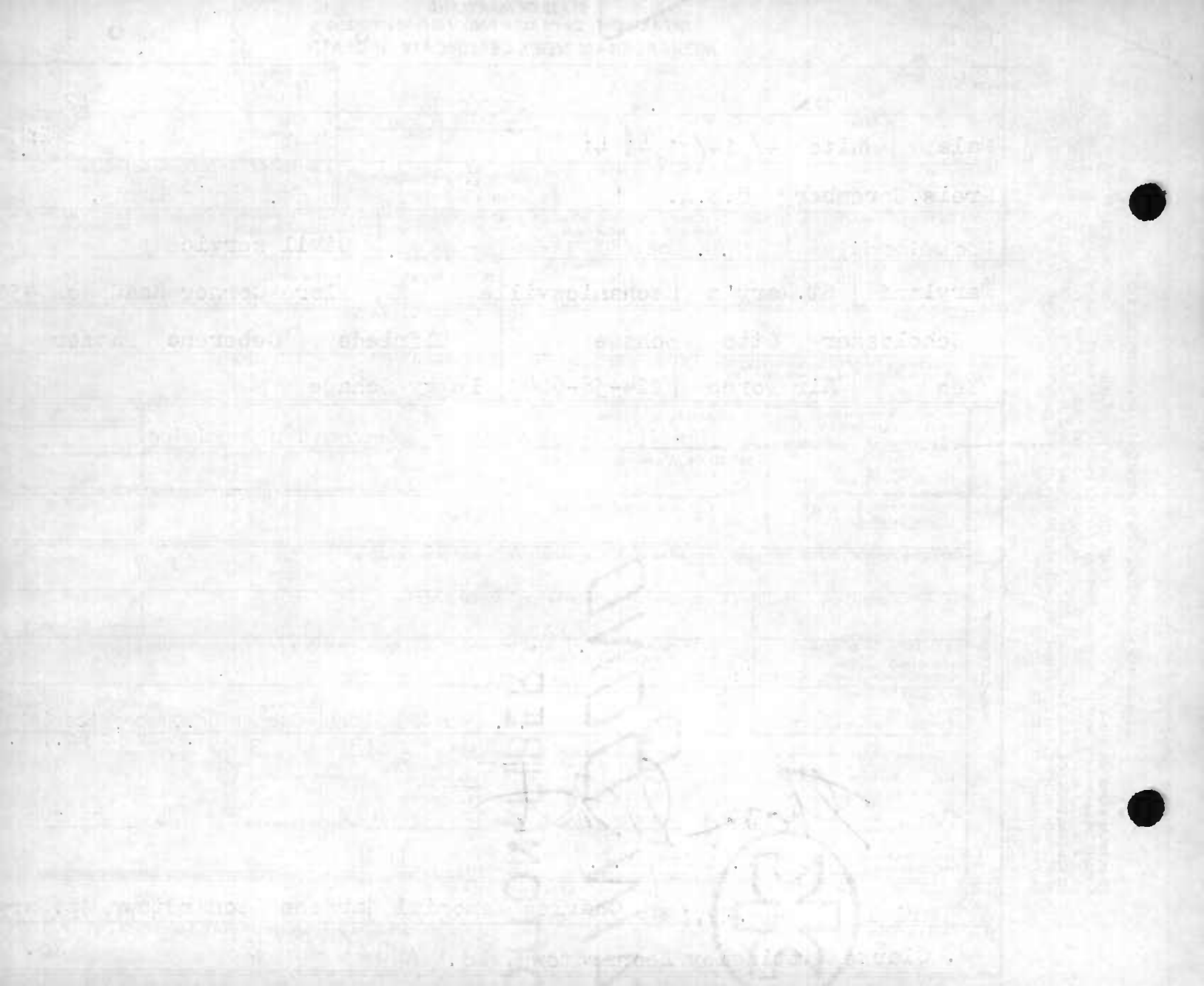
BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21964  
REG. NO.

12  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Horst G. Schade			2a. DATE KNOWN OF DEATH ESTIMATED 8 14 19 82			2b. HOUR M 2:15 a.m.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4/ 14/ 1941	6. AGE (IN YEARS) (LAST BIRTHDAY) 41 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD 8 15 19 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kreis, Spremberg		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County, MD.		
10. CITY OR TOWN OF DEATH Mechanicsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Box 450 Floral Corner Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil service		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Schollosser Otto Schade			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elfriede Geberene Patzer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Air Force 224-58-6040		17. INFORMANT Peggy Schade			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9654 Multiple Gunshot Wounds (weapon not specified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR 11:50 AM 8 14 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION CITY OR TOWN COUNTY STATE P.O. Box 450 Floral Corner Rd., Mechanicsville, St. Mary's Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Thomas D. Smith, M.D.			TITLE (SPECIFY) Deputy Chief			DATE SIGNED 8-16-82		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown St. Mary's	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley			ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR AUG 20 1982		25b. REGISTRAR'S SIGNATURE J. G. Smith Md.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8 2 2 1 9 6 5				
1. DECEASED NAME (TYPE OR PRINT) <b>HAROLD FREDERICK SCHLOSSER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>August 5, 1982</b>			2b. HOUR <b>10:52 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 8, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County MD</b>			
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Leonardtwn</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Cedar Lane Apartments</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Otto Schlosser</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Augusta Matelusch</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>158-07-0146</b>		17. INFORMANT ADDRESS <b>Donald A. Schlosser, Hollywood, Maryland Rt. #2, Box 552</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute ant. MI</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>VENTRICULAR Fibril</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF <b>Comp. I. Block</b> (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.									
22b. SIGNATURE <b>V. K. Shah, M.D.</b> DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. K. Shah, M. D.</b>					22e. ADDRESS <b>Leonardtwn, Maryland 20650</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-9-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Catholic</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hollywood, St. Mary's, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brinsfield Funeral Home, Leonardtown, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

MEDICAL CERTIFICATION

9 9

BP \_\_\_\_\_

10:45

August 2, 1982

HAROLD THOMPSON SCHWABER

St. Mary's County

St. Mary's Hospital

Leonardtown

Leonardtown, Maryland 20620

V. M. Smith, M. D.

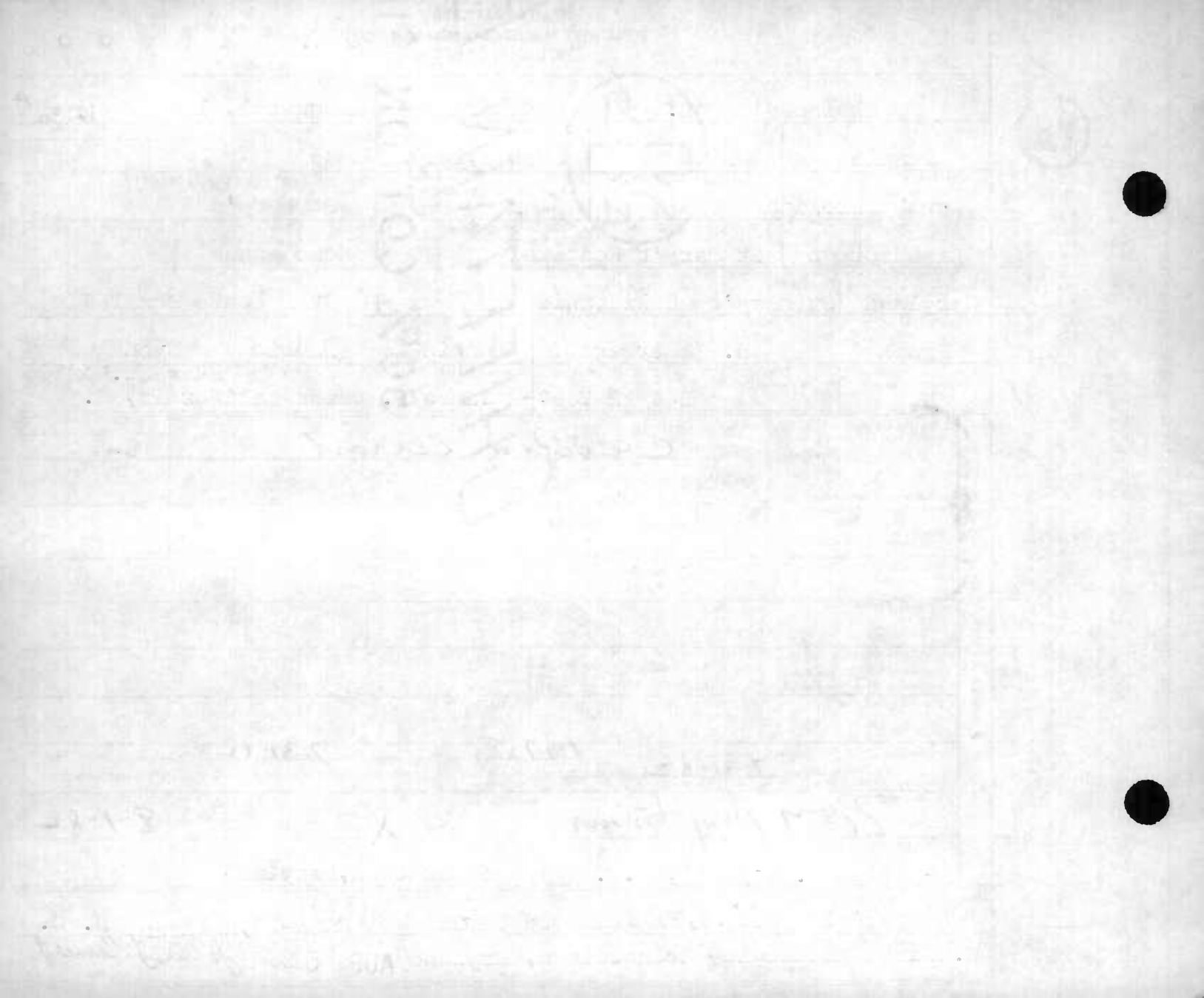
20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of on

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 1 9 6 6	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eloise B. Seward</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>August 1, 1982</b>			2b. HOUR <b>12:30 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 2, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St Mary's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>St Mary's</b>		13c. CITY OR TOWN <b>California</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Star Route Box 166</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank H. Herbert</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Laurie Wynn</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>244 12 2887</b>		17. INFORMANT ADDRESS <b>A James E. Burns California, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sec.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , 19____, to <b>7-31-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>7-31-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wm Boyd</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8-1-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd 11, M.D.</b>				22e. ADDRESS <b>Leonardtwn, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 3, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Enfield, Halifax N. C.</b>					
24. FUNERAL DIRECTOR <b>W. Clarke Mattingley Leonardtown, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Smith</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				6 2 2 1 9 6 7			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond Elmer Sibley</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8-29-82</b>		2b. HOUR <b>3:56PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 13, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>75</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ST. Marys County</b>	
10. CITY OR TOWN OF DEATH <b>Lexington Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Amber House Nursing Facility</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Charles Indian Head</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>36 Old Indian Head Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Daniel Sibley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie M. Kidd</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>578-05-3207</b>		17. INFORMANT ADDRESS <b>1505 South First St., Jackson- Benjamin D. Sibley, 3rd. Florida Beach</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 11, 1982</b> , to <b>Aug. 29, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Aug. 29, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Benjamin D. Sibley</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. E. B. Sibley, II MD</b>				22e. ADDRESS <b>Leonard Town, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Rest Cemetery La Plata</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Charles Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>G. A. Powell</b>	

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 9 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LILA MAE SUTOR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 31, 1982</b>		2b. HOUR <b>02:44A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 23 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waitress</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b>			13c. CITY OR TOWN <b>Chesapeake Beach</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>- unk -</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>- unk - Thompson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-03-3634</b>		17. INFORMANT ADDRESS <b>David Rowley same co #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Artery</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Dysfunction</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>82</b> , to <b>8/31</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/31</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not notice the body after death, so state.)					
22b. SIGNATURE <b>James C. Boyd, M.D.</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>Leonardtwn, Maryland 20650</b>	
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <b>Burial</b>		23b. DATE <b>9-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Southern Maryland Burial Monument</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beltsville Prince Georges MD</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 7 1982</b>		23f. REGISTRAR'S SIGNATURE <b>John J. P. [Signature]</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rauch Funeral Home [Signature]</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NAME SURNAME DATE

St. Mary's County  
St. Mary's Hospital

NO

James C. Boyd, M.D.  
Hennepin County, Minnesota

20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						2. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST (TYPE OR PRINT) <b>MADELINE KATHERINE TULIS</b>						<b>August 4, 1982</b>						<b>7:53P M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 4, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County MD</b>							
10. CITY OR TOWN OF DEATH <b>Leonardtown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Laurel Grove</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 164</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Francis Kenney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Theresa Guinnan</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>031-18-6010</b>		17. INFORMANT ADDRESS <b>Hospital Records Leonardtown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cocaine</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19____, to <b>August 5, 1982</b> , that (I) (we) last saw the deceased alive on <b>7-19-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Wm Boyd II</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/6/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd II, M.D.</b>						22e. ADDRESS <b>Leonardtown, Md., 20650</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/6/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>California St. Mary's Md</b>					
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b>						ADDRESS <b>Leonardtown, Md.</b>		25a. DATE RECD. BY REGISTRAR <b>AUG 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>			

BP

THE UNIVERSITY OF CHICAGO  
LIBRARY

1952

August 11, 1952

MASSIVE KATAMIRI JULIE

Yonkers

Chancellor

St. Mary's County

St. Mary's Hospital

Leominster

1952

St. Mary's Hospital

Leominster

St. Mary's Hospital

Leominster

St. Mary's Hospital

Leominster

Leominster, Mass. 01550

William H. Hoy II, M.D.

1952

St. Mary's Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 8 2 2 1 9 7 0							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Wathen Uhler			2a. DATE OF DEATH MONTH DAY YEAR Aug. 25, 1982				2b. HOUR 2:27 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 4, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oakville, Md.		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.				
12. CITY OR TOWN OF DEATH Lexington Pk.		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY St. Mary's		16c. CITY OR TOWN Mechanicville		16d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		16e. STREET ADDRESS General Delivery	
17. FATHER'S NAME FIRST MIDDLE LAST George Frederick Wathen			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Romaine Watson							
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			20. SOCIAL SECURITY NO.		21. INFORMANT ADDRESS Sterling H. Uhler same as 13e					
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm of the brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
23. DATE OF OPERATION			24. CONDITION FOR WHICH OPERATION WAS PERFORMED				25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
30. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE					
33. I certify that (I) (this hospital) attended the deceased from <u>7-20-82</u> , 19 <u>82</u> , to <u>8-25-82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8-9-82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
34. SIGNATURE <u>Wm D. Boyd R.M.D.</u>			35. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		36. DATE SIGNED 8-26-82					
37. PHYSICIAN'S NAME (TYPE OR PRINT) Wm D. Boyd R.M.D.			38. ADDRESS							
39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			40. DATE 8/28/82		41. NAME OF CEMETERY OR CREMATORY St. John's		42. LOCATION CITY OR TOWN COUNTY STATE Hollywood St. Mary's Md.			
43. FUNERAL DIRECTOR NAME W. Clarke Mattingley			44. ADDRESS Leonardtwn, Md.		45. DATE REC'D BY REGISTRAR AUG 31 1982		46. REGISTRAR'S SIGNATURE <u>John J. Connelley</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 2 2 1 9 7 1			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST (TYPE OR PRINT) JOSEPH CLYDE VALLANDINGHAM				2a. DATE OF DEATH MONTH DAY YEAR August 29, 1982		2b. HOUR 12:15A <sub>M</sub>	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 years YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN St. Mary's		13c. STREET ADDRESS Bushwood	
14. FATHER'S NAME FIRST MIDDLE LAST George Lawrence Vallandingham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Mae Quade			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-1509A		17. INFORMANT ADDRESS Maude G. Vallandingham same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cerebrovascular Attacks</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>79</u> , to <u>8/29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James C. Boyd M.D.				22e. ADDRESS Leonardtown, Md. 20650			
23a. BURIAL, CREMATION, REMOVAL (SICEST) Burial		23b. DATE 8/31/1982		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION CITY OR TOWN COUNTY STATE Bushwood St. Mary's Md.	
24. FUNERAL DIRECTOR W. Clarke Mattingley				25a. DATE REC'D. BY REGISTRAR SEP, 2 1982		25b. REGISTRAR'S SIGNATURE 	





NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 checked, any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be held and a report filed.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 1 9 7 2

1. DECEASED NAME (TYPE OR PRINT) Earl Wesley White			2a. DATE OF DEATH MONTH DAY YEAR Aug. 25, 1982			2b. HOUR 3:45 PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St/ Mary's MD.		
10. CITY OR TOWN OF DEATH Lexington Pk.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk police dept.		
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hutcheson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Marian E. White - Same As # 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>Recurrent Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Rheumatoid Arthritis</u> <u>Peripheral Vascular disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21a. INJURY OCCURRED WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>82</u> , to <u>8/25</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>James E. Boyd M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-25-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Boyd M.D.				22e. ADDRESS P.O. Box 301 Leonardtown Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Geo. MD		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 26 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		
6631 Old Alexander Ferry Rd., Clinton, MD								

THE UNIVERSITY OF CHICAGO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21973	
1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		James Roger Williams Sr.								2b. HOUR 1300	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 22, 1915		6. AGE (IN YEARS) 67 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		2c. DATE PRONOUNCED DEAD 8-20-82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's		2d. HOUR 1600			
10. CITY OR TOWN OF DEATH Mechanicsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 563			
14. FATHER'S NAME Peter Douglas Williams		15. MOTHER'S MAIDEN NAME Pearl Vergie Williams		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Ada Augusta Williams		ADDRESS same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mon	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Wm J Boyd</u>		TITLE (SPECIFY) M.D. <u>Deputy</u>		MEDICAL EXAMINER				DATE SIGNED 8-21-82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 23, '82		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial		23d. LOCATION CITY OR TOWN Waldorf		COUNTY Charles		STATE Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtown, Md.		25a. DATE REG. BY REGISTRAR AUG 23 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Connelley</u>					

1000 COTTON

1000 COTTON



1000 COTTON

1000 COTTON

1000 COTTON

1000 COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21974  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH										2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		ESTIMATED		MONTH DAY YEAR		19 82 1000	
John Edward Winalski								XX 8-8		19 82		1000	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male	White	12 5 1959		22 YRS.						8 9 19 82		0850	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Florida		U.S.A.										St. Mary's MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY							
Lexington Park		Willows Road											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		St. Mary's		Lexington Pk.		YES NO		201 Patuxent Drive					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Joseph Stanley Winalski		Julia Marie Amato											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		046-52-6276		Carol Ann Winalski		same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:												30 MIN.	
IMMEDIATE CAUSE (a) CARBON MONOXIDE POISONING													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
										YES NO X			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED									
XX		1000 AM? 8-8 19 82		Self-inflicted carbon monoxide poisoning									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION									
X		Willows Road		Willows Road Lexington Park St. Mary's Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner													
TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED 8/9/82													
ACTUAL SIGNATURE		M.D. DEPUTY MEDICAL EXAMINER								DATE SIGNED			
William D. Boyd, M.D.		Leonardtwn, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		Aug. 13, 1982		Riverside Cemetery		Farmington Hartford Conn.							
24. FUNERAL DIRECTOR		25a. RECORD BY REGISTRAR											
W. Clarke Mattingley		Leonardtwn, Md.											

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